

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: TN3301	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/31/2011
NAME OF PROVIDER OR SUPPLIER ALEXIAN VILLAGE OF TENNESSEE			STREET ADDRESS, CITY, STATE, ZIP CODE 671 ALEXIAN WAY SIGNAL MOUNTAIN, TN 37377		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
N 000	Initial Comments During the annual Licensure survey and complaint investigation #28103, conducted from August 29, 2011 through August 31, 2011, at Alexian Village of Tennessee, no deficiencies were cited under Chapter 1200-8-6, Standards for Nursing Homes.	N 000			09/17/11

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TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

6899

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If continuation sheet 1 of 1

SEP 16 2011